STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING _____ B. WING _____	C 02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN 46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00084367. Complaint IN00084367 - Substantiated, Federal/State deficiencies related to the allegations are cited at F319. Survey dates: 2/1 and 2/3/11 Facility number: 000521 Provider number: 155582 AIM number: 100266980 Survey Team: Ellen Ruppel, RN, TC Mavis Stob, RN Census bed type: SNF: 10 SNF/NF: 106 Total: 116 Census payor type: Medicare: 14 Medicaid: 77 Other: 25 Total: 116 Sample: 4 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 2/9/11 by Jennie Bartelt, RN.	F 000	RECEIVED FEB 18 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	F 319	**F-Tag 319 TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES:** It's the policy of Miller's Merry Manor of Wakarusa that the facility ensure that a resident who displays mental or psychoactive adjustment difficulty receives appropriate treatment and services to correct the assessed problem. ***Resident #B:*** *Senior Counseling Services completed initial assessment/visit on 2/4/2010. Weekly visits have occurred on 2/9/11, 2/16/11. HCP has been reviewed and revised to include interventions to assist resident to adapt to nursing home life and guardianship issues.*	2/17/11

app 2/23/11 BM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Randy R. Baughman ADMINISTRATOR 2-16-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 319	Continued From page 1 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure 1 of 2 residents with psychosocial adjustment difficulty in a sample of 4 received appropriate interventions to adapt to nursing home life and guardianship issues. Resident B Findings include: The clinical record of Resident B was reviewed on 2/1/11 at 10:45 a.m., and indicated the resident had been admitted to the facility in August of 2010 as a resident using Medicare benefits for payment. Her diagnoses included, but were not limited to: anemia, dysphagia, history of malignant neoplasm of the breast and dementia. At the time of admission on 7/8/10, the resident's son was her POA (Power of Attorney). Nurse's notes, dated 9/25/10 at 3:54 p.m., indicated the resident had expressed, "I'd much rather be dead, then (sic) be here." The entry also indicated the resident had told the nurse, "When I try to talk to my son, he always gets upset and short with me. They just want to spend my money and forget me. They won't even take me out for a short trip in the car, or take me to see my home for a while, then bring me back." Nurse's notes of 11/28/10 at 8:16 p.m., indicated the resident was upset and told the nurse she	F 319	All residents have the potential to be affected by the deficient practice. The unit managers and social service director completed a chart audit by 2/16/11 to ensure that all residents who are experiencing/displaying mental or psychosocial adjustment is receiving appropriate treatment and/or outside services to correct the assessed problem. A nursing in-service was completed on 2/17/11 to discuss the process for communicating to social services when a resident exhibits mental/psychoactive adjustment difficulty and to document findings on the 24hour report tool. The 24hour report tool is reviewed daily by members of the team as a communication tool regarding changes in resident status. Social services will work with nursing to request orders from physician to have outside mental health services assess and treat. Social services director or other designee will be responsible to promptly follow up and arrange for outside mental health services after receipt of order from physician for treatment. The QA tool "Social Services Review" will be completed by the social service director or other designee weekly for 4weeks then monthly thereafter to ensure ongoing compliance. Any identified trends will be documented on	2/17/11

Administrator 2-16-11

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F 319	Continued From page 2 was just sitting around praying that she would die. Social Service notes of 12/20/10 at 11:04 a.m., indicated, "Resident was asking fincial (sic) and facility questions. Writer and business office manager answered questions and provided resident with a copy of facility room daily rates and other requested items. Provided resident with an estimated monthly cost by multiplying room rate of $225 for a semi private by 30. Resident voiced surprise (sic) by rates. Writer will contue (sic) to answer residents questions and refer resident as needed." Review of the billing statements indicated the resident's bill was not being paid, and an involuntary discharge notice was issued. The facility issued a discharge notice on 11/24/10, due to non payment. A hearing was held on 12/17/10, and the administrative law judge determined, "The proposed location appears not to represent a safe and orderly discharge." The determination also indicated the outstanding balance of the account was $33,507.84, and efforts to obtain Medicaid had not been successful. The discharge was denied. The hearing information indicated the resident's son, the Adult Protective Services representative, the Ombudsman, facility staff members and a court reporter had been present at the hearing. Social Service notes of 1/4/11 at 3:17 p.m., indicated Resident B was upset and indicated she needed to give money to her son since he did not have money to make a car payment. The Ombudsman and Adult Protective Services staff member were notified. Review of a temporary guardianship order, dated	F 319	QA log and reviewed during the facility monthly QA calls. System changes will be completed by 2/17/2011.	2/17/11

2/16/11

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F 319	Continued From page 3 1/7/11, indicated (an agency on aging) had sought and obtained temporary legal guardianship of Resident B effective 1/7/11. This was in response to concerns regarding the way the resident's money was being handled and the nursing home not being paid for her care. Social Service notes of 1/7/11 at 1:25 p.m., indicated the resident voiced understanding that she needed to be protected from her son. The note also indicated she became upset when the social worker explained all of her funds would be going to the facility with $52.00 being deposited for the personal needs. Nurse's notes at 10:26 p.m. on 1/9/11, indicated the resident had been upset and heard on the phone talking about her finances, and had stated, "Well I will solve this problem I will commit suicide." The note indicated 15 minute checks were started, and the resident's guardian and the Director of Nursing were notified. The newly appointed guardian also requested supervised visits and no phone calls until further notice specifically for the son. Social Service notes of 1/11/11 at 4:05 p.m., indicated the state police had met with Resident B regarding possible misappropriation of her funds. Nurse's notes on 1/11/11 at 10:14 p.m., indicated the resident was sitting on the bed with her head in her hands and began talking about her family dynamics. She indicated "He took my house, my car and my money. I worked for that money. My husband worked for that money. That's my money and no one else's." She indicated to the nurse she knew she had signed a paper to prevent her son from access to the money and	F 319		2/17/4

2/16/11

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F 319	Continued From page 4 she had no current plan to hurt herself. She also indicated two of her family members had committed suicide. Social Service notes of 1/12/11 at 3:29 p.m., indicated the 15 minute checks were changed to 30 minute checks due to the resident denying the will to hurt herself. Physician's orders, dated 1/14/11, indicated (senior counseling services) were to evaluate and treat due to her depression. Remeron 30 mg daily was also started for her depression. Nurse's notes of 1/22/10 at 10:46 p.m., indicated the senior counseling services had been postponed due to a question of payor source. The care plan related to feelings of sadness, emptiness, anxiety, uneasiness, depression, low self esteem, withdrawal, tearfulness and recent loss, dated 1/14/11, indicated, in part: "assist resident as needed with senior counseling services." The care plan dated 1/9/11 and 1/12/11, related to negative statements such as she would be better off dead, included interventions: 30 minute checks document on tool, 1:1 (one on one) supervision as needed, resident's son is not to visit without prior scheduled time and supervision per guardian, resident is not to talk to her son on the phone at this time per guardian, and utilize any available resources for treatment, provide 1:1 prn (as needed). The Director of Nursing was interviewed on 2/1/11 at 2:30 p.m., about the 1/14/11 order for the senior counseling services and not having	F 319		2/17/11

2-16-11

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F 319	Continued From page 5 obtained the senior counseling agency. She indicated the payor source had not been established and the service had declined Resident B's care. When queried about provision of services from another agency, she indicated the facility had not contacted other psychological services. The resident was not receiving the services of any counseling group on 2/1/11. This federal tag relates to Complaint IN00084367. 3.1-43(a)(1)	F 319		2/17/11

2-16-11